REPORT OF FACILITY CHANGES/ADDITIONS

Please note any changes and submit this form to DWI Services within 10 working days of any change/addition. Attach documentation as necessary.

Facility: _____ **DWI Facility Code:** _____

Mental Health License #: _____ **Expiration Date:** _____

Facility/Staffing Info	**Does information need to be changed/added?**	**If checked yes, indicate change(s) below**
Facility name	Change ☐yes ☐no	
Mental health license/exp date	Change ☐yes ☐no	
Location	Change ☐yes ☐no	
Mailing address	Change ☐yes ☐no	
Telephone	Change ☐yes ☐no	
Fax #	Change ☐yes ☐no	
Email	Change ☐yes ☐no	
Facility website	Change ☐yes ☐no	
Owner/management entity	Change ☐yes ☐no	
Clinical director	Change ☐yes ☐no	
Direct care staff (must send NCSAPPB credentials)	Change ☐yes ☐no	
Contact person for DWI	Change ☐yes ☐no	
Hours of operation	Change ☐yes ☐no	
Dwi program components	Change ☐yes ☐no	

Signature (Administrative Director): _____Date: _____

Name/Title: _____

Please fax to DWI Services- 919-733-4665

Mail to: NC Division of MH/DD/SAS
Justice Systems, DWI Services
3008 Mail Service Center
Raleigh, NC 27699-3008
ATTN: Lynn Jones